STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155707	A. BUILDING 01 B. WING	10/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWISS VILLAGE INC	1350 W MAIN ST BERNE, IN46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/03/11 Facility Number: 000280 Provider Number: 155707 AIM Number: 100274540 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Swiss Village Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V(111) construction	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and resident room. The facility has a capacity of 128 and had a census of 118 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/06/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0025 SS=D	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide	K0025	**POC** (1) A sprinkler pipe penetrating the ceiling of the Sonnablum's janitor closet was identified by the surveyor as being out of compliance because of an	11/03/2011

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	a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect any number of staff in the Sonnenblum janitors closet. Findings include: Based on observation with Maintenance Technician # 1 on 10/03/11 at 1:45 p.m., there is a one inch unsealed gap around the sprinkler line which penetrates the ceiling of the Sonnenblum janitors closet. Measurements were provided by Maintenance Technician # 1 at the time of observation. 3.1-19(b)		unsealed gap between the pipe and the ceiling. The gap has been sealed with a fire stop sealant to provide a continuous smoke seal in that room. (2) A visual inspection was conducted to assure all other rooms have a continuous smoke barrier. No other penetrations were discovered. (3) Plant Operations and Maintenance Supervisor will manage the inspection of all areas quarterly to assure compliance. (4) The results of the visual inspection will be documented and reported to The Quality Assessment & Assurance Committee quarterly.	

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K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 2 Edelweiss soiled utility rooms was provided with a self closing device. This deficient practice could affect any resident near the Edelweiss west wing soiled utility room. Findings include: Based on observation with Maintenance Technician # 1 on 10/03/11 at 1:15 p.m., the Edelweiss west wing soiled utility room, containing one container of soiled linen and one container of soiled personnel clothing, had a corridor door which was not equipped with a self closing device. This was confirmed by Maintenance Technician # 1 at the	K0029	**POC** (1) The door to the Edelweiss's Place west wing soiled utility room was identified by the surveyor as being out of compliance because it did not have a self-closing device. A door closure was installed on the soiled utility room door. (2) A visual inspection was conducted to assure that all soiled utility rooms had self-closing doors. No other corridor doors for a soiled utility room were discovered without a self-closure. (3) The Plant Operations and Maintenance Supervisor will manage the inspection of all areas quarterly to assure that corridor doors requiring self-closures, are properly installed and functioning. (4) The Plant Operations and Maintenance Supervisor will provide quarterly documentation to the Quality Assessment & Assurance Committee on the results of the above inspection for there review and approval.	11/03/2011

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	time of observation. 3.1-19(b)			
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 3 Edelweiss exits was readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates,	K0038	**POC** (1) The Edelweiss activity room exit door extending out and around a fountain was identified by the surveyor as being out of compliance for not continuing to the public way. In reviewing this exit with the architect we have discovered that this is not a required exit to meet the code requirements. There are two other exits that do not exceed the distance of 150 feet and do empty unto a hard surface that can be used for emergency exit to the public parking lot. None of the existing emergency evacuation maps show this door as an exit. We propose that the exit sign over this door be removed and that the door be labeled as “No Exit.” (2) No other doors have an exit sign overhead that do not provide a hard surface to a public parking area. (3) Staff will be in-serviced, instructed that the door in question is not an emergency exit. (4) The Plant Operations and Maintenance Supervisor will report to the Quality Assessment & Assurance Committee when	11/03/2011

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	or soft ground during heavy periods of rain. This deficient practice could affect any occupants evacuated through Edelweiss activity room exit. Findings include: Based on observation with Maintenance Technician # 1 on 10/03/11 at 1:05 p.m., the exit egress sidewalk from the Edelweiss activity room exit door extended out and around a center fountain but did not continue to the public way. Based on an interview with Maintenance Technician # 1 at the time of observation, it was sixty six feet to the public way from said sidewalk. 3.1-19(b)		the above work is completed.	
K0046 SS=E	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and interview, the facility failed to provide exterior emergency lights for 1 of 3 Edelweiss exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge.	K0046	**POC** (1) Additional emergency lighting will be installed on the Edelweiss north wing to provide lighting for the applicable emergency exit path. (2) All exit-discharge paths have been reviewed to verify adequate emergency lighting. (3) A visual inspection of all	11/03/2011

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	This deficient practice could affect any occupants evacuated through the Edelweiss north wing emergency exit door. Findings include: Based on observations with Maintenance Technician # 1 on 10/03/11 at 12:55 p.m., an exterior light fixture was observed on the side of the building near the Edelweiss north wing exit door, but the exit discharge path continued for another one hundred and twenty feet then made a ninety degree turn and continued on, running parallel with the road. Based on an interview with the Maintenance Technician # 1 at the time of observation, the exit discharge path by the road would not have emergency lighting coverage. 3.1-19(b)		emergency exit paths will be conducted semi-annually to verify that tree and shrub growth is not blocking emergency path lighting and that there is adequate emergency lighting. (4) The Plant Operations and Maintenance Supervisor will document the semi-annual inspection for adequate emergency lighting of all emergency exit paths and submit a copy to the Quality Assessment & Assurance Committee.	

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K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on record review of the "Report of Quarter Fire Drill" with Maintenance Technician # 1 on 10/03/11 at 11:05 a.m., there was no record of a second shift fire drill for the third quarter of 2011. Based on an interview with Maintenance Technician # 1 at the time of record review, no other documentation was available for review to verify this drill was conducted. 3.1-19(b)	K0050	**POC** (1) Quarterly fire drills do occur on all shifts and in fact did occur during the second shift and in the third quarter. See Exhibit 1. Unfortunately the Plant Operations and Maintenance Supervisor who initiates and documents the fire drills was away from the facility on vacation during the LSC survey and even though the documentation was completed and in the designated book binder, Maintenance Technician # 1 was not able to find and produce the documentation for the surveyor. (2) The Plant Operations and Maintenance Supervisor reviewed the contents and location of fire drill documentation with Maintenance Technician # 1, Director of Healthcare Services, Director of Resident Services and Executive Director so that in the future it can be found and produced during the survey. (3) The Plant Operations and Maintenance Supervisor will produce a duplicate copy of the documentation and provide to the	11/03/2011

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	3.1-51(c)		Director of Healthcare to verify timely logging of fire drills. (4) The Plant Operations and Maintenance Supervisor will report quarterly to the Quality Assessment & Assurance Committee verifying that documentation is readily available to confirm that fire drills are occurring on each shift, each quarter.	
K0052 SS=E	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure a testing and a battery replacement program was provided to ensure 23 of 23 single station smoke detectors would operate. This deficient practice affects 34 residents in the Lavendel and Alpenrose wings. Findings include: Based on record review with the Maintenance Technician # 1 on 10/03/11 at 12:00 p.m., the facility could not provide documentation of a monthly test and a battery replacement program for the twenty three	K0052	**POC** (1) Each of the 23 single station smoke detectors in the healthcare resident rooms was tested to verify that they are functioning. See Exhibit 2. (2) After further review it was discovered that there are 29 single station smoke detectors with all other smoke detectors in the resident rooms being hardwired and not dependent on battery power. The remainder of the single station battery powered smoke detectors were tested and verified as functioning. (3) A written program for the testing and replacement of batteries in battery smoke detectors was downloaded from Indiana.gov. This form was used as the basis to create a form to document the monthly testing of the 29 single station smoke	11/03/2011

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	single station smoke detectors in resident rooms on the Lavendel and Alpenrose wings. Based on an interview with Maintenance Technician # 1 at the time of record review, he was unable to locate documentation to verify the facility had a program. 3.1-19(b)		detectors. (4) Plant Operations and Maintenance Supervisor will manage and document the monthly inspection of all battery-powered smoke detectors within the facility. This inspection document will be reported to The Quality Assessment & Assurance Committee quarterly.	
K0056 SS=D	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads installed in the Alpenrose clean linen room was at least four inches from the wall. NFPA 13, 5-6.3.3 requires upright and pendant sprinkler heads shall be installed at least four inches from	K0056	**POC** (1) One sprinkler head located in Alpenrose clean utility room was identified by the surveyor as being out of compliance because sprinkler head was installed two inches from the wall. The sprinkler contractor has moved the sprinkler head to meet NFPA code 5-6.3.3. (2) A survey of the facility was conducted to assure none of the	11/03/2011

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	the wall. This deficient practice was not in a resident care area but could affect a limit number of staff. Findings include: Based on observation with Maintenance Technician # 1 on 10/03/11 at 12:16 p.m., the sprinkler head in the Alpenrose clean linen room was mounted next to the wall. Based on an interview with Maintenance Technician # 1 at the time of observation, the sprinkler head was located two inches from the wall. 3.1-19(b)		other sprinkler heads in the facility were within 4 inches of the wall. (3) The above visual inspection confirmed that there are no other existing sprinkler heads within 4 inches of a wall. (4) Plant Operations and Maintenance Supervisor will oversee and review with the sprinkler installer the location to make sure future sprinkler head installations meet the requirement to be at least 4 inches from the wall.	
K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure cubicle curtains installed in	K0062	**POC -1**(1) Three of the six shower rooms were identified by the surveyor as being out of compliance because the mesh	11/03/2011

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	3 of 6 shower rooms were in accordance wit NFPA 13, Standard for the Installation of Sprinkler Systems. The lack of cubicle curtain and sprinkler location coordination may obstruct the sprinkler spray onto the fire or may shield the heat from the sprinkler. This deficient practice could affect any resident in the Sonnenblum short and long hall shower rooms and the Edelweiss west wing shower room. Findings include: Based on observations with Maintenance Technician # 1 on 10/03/11 from 11:50 a.m. to 1:42 p.m., the shower rooms on the Sonnenblum short and long halls and the Edelweiss west wing shower room had privacy curtains lacking 1/2 inch diagonal mesh or a 70 percent open weave top panel extending 18 inch below the sprinkler deflector. This acknowledged by Maintenance Technician # 1 at the time of observations. 3.1-19(b)		portion of the shower curtains were not ½ mesh or a 70% open weave at the top panel extending 18 inches below the sprinkler deflector. These curtains will be replaced. Shower curtains have been ordered having an 18inch open mesh that meets the NFPA 13 code. See Exhibit 3 for purchase order.(2) All other curtains were visually inspected to verify that they complied with the ½ inch diagonal mesh or a 70% open weave top panel extending 18 inches below the sprinkler deflector.(3) Plant Operations and Maintenance Supervisor will over-see future replacement of shower curtains to assure they meet the NFPA 13 standard.(4) The Plant Operations and Maintenance Supervisor will quarterly visually inspect shower curtains and log compliance and report results to the Quality Assessment and Assurance Committee. **POC -2** (1) Three sprinkler heads were identified by the surveyor as being out of compliance because of obstruction cause by the positioning of the light fixtures too close to the sprinkler heads. These sprinkler heads have been lowered, allowing for the free flow of the spray. (2) The Plant Operations and Maintenance Supervisor visually inspected the locations of sprinkler heads to verify that the spray is not impeded by the	

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	2. Based on observation and interview, the facility failed to ensure the spray pattern for 2 of 2 sprinkler heads in the Lavendel medication room and 1 of 1 sprinkler heads in the Lavendel time clock room were unobstructed. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice was not in a resident care area but could affect any number of staff. Findings include: Based on observations with Maintenance Technician # 1 on 10/03/11 from 12:21 p.m. to 12:22 p.m., the spray pattern of two sprinkler heads in the Lavendel medication room and one sprinkler head in the Lavendel time clock room were obstructed by ceiling light fixtures. Based on		location of adjacent light fixtures. (3) The Plant Operations and Maintenance Supervisor will oversee and review with the sprinkler contractor the future placement of sprinkler heads to assure that light fixtures do not impede the spray pattern of any sprinkler heads. (4) The Plant Operations and Maintenance Supervisor will visually inspect quarterly the location of sprinkler heads to verify that light fixtures are not obstructing the spray pattern and verify compliance to the Quality Assessment and Assurance Committee.	

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	an interview with Maintenance Technician # 1 at the time of observation, the ceiling light fixtures were mounted four inches from the sprinkler heads. 3.1-19(b)			
K0064 SS=E	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to inspect 2 of 2 kitchen fire extinguishers and 1 of 1 Lavendel beauty shop fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been	K0064	**POC** (1) A tag has been placed on the fire extinguisher in the Lavendel beauty shop and an inspection notation was made on the kitchen fire extinguisher tag for the month of October. (2) All other fire extinguishers were inspected, initialed, dated and tagged to verify that they are charged, operable and in the right location. (3) A log has been created listing all extinguisher locations so that no extinguisher is missed for the required monthly inspection. (4) The Plant Operations and Maintenance Supervisor will oversee that future fire extinguisher inspections are logged and that all new fire extinguishers are inspected and tagged prior to placement. In addition the Plant Operations and Maintenance Supervisor will verify to the Quality Assessment &	11/03/2011

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	actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect any number of residents in the Lavendel beauty shop as well as any number of kitchen staff. Findings include: Based on observations with Maintenance Technician # 1 on 10/03/11 from 2:05 p.m. to 2:22 p.m., the monthly inspection tag for the kitchen fire extinguishers lacked documentation of a monthly inspection for September 2011. Additionally, the fire extinguisher in the Lavendel beauty shop lack an annual and monthly inspection tag. This was acknowledged by Maintenance Technician # 1 at the time of observations. 3.1-19(b)		Assurance Committee that the monthly inspections of all extinguishers are being performed.	
K0069 SS=E	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing	K0069	**POC** (1) The semi-annual inspection of the hood extinguishing system occurred in September but the	11/03/2011

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	systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect all resident in the dining room in the event of an emergency. Findings include: Based on record review with Maintenance Technician # 1 on 10/03/11 at 2:52 p.m., the only hood extinguishing system inspection was by Koorsen on 03/01/11. Based on an interview with the Maintenance Technician # 1 at the time of record review, no other documentation was available for review. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 1 K Class portable fire extinguishers in the kitchen cooking area in accordance with		paper work was not received until 10/11/2011 (See Exhibit 4 dated 9-26-11). A placard has been installed above the portable "K" fire extinguisher advising that the hood extinguishing system is to be activated prior to using the portable class K extinguisher. (2) Swiss Village only has the one hood extinguishing system that was addressed in the above section. (3) The Plant Operations and Maintenance Supervisor will oversee that semi-annual inspections are completed on time and that all kitchen employees are in-serviced on the use of the portable class K fire extinguisher in the kitchen area. (4) The Plant Operations and Maintenance Supervisor will report to the Quality Assessment & Assurance Committee semi-annually on the receipt of the documentation verifying the completion of the hood extinguishing system test and the proper placement of the instructional placard above the portable class K extinguisher.	

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	the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents in the main dining room. Findings include: Based on observation with Maintenance Technician # 1 on 10/03/11 at 2:23 p.m., the kitchen K Class fire extinguisher			

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	lacked a placard. Based on an interview with the Maintenance Technician # 1 at the time of observation, the kitchen K Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen automatic fire suppression system. 3.1-19(b)			
K0070 SS=E	Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation and interview, the facility failed to provide a policy for the use of 1 of 1 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect any number of residents and staff when the space heater is in use. Findings include: Based on an observation with Maintenance Technician # 1 on 10/03/11 at 1:10 p.m., a space heater was stored in the Edelweiss	K0070	**POC** (1) A policy has been written that portable heating devices cannot be used in any occupancy areas and only temporarily in non-sleeping staff and employee areas where the heating element of such devices does not exceed 212 degrees F. (Exhibit 5) (2) All portable heating units were inventoried and moved to a storage area secure from occupancy areas (Storage Room 101). (3) The Plant Operations and Maintenance Supervisor will oversee and maintain the log of the location of all portable heating devices to verify that they are not being used in occupancy areas. (4) The Plant Operations and	11/03/2011

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	west wing storage closet. Based on an interview with Maintenance Technician # 1 during the record review process from 11:05 a.m. to 11:50 p.m., the facility does not have a policy regarding space heaters. 3.1-19(b)		Maintenance Supervisor shall report to the Quality Assessment & Assurance Committee on a quarterly basis how portable heaters are being used and how they are stored when not in use.	
K0071 SS=E	Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 Based on observation and interview, the facility failed to provide automatic extinguishing	K0071	**POC** (1) A sprinkler head has been installed in the laundry chute.(2) There are no other laundry or rubbish chutes in other	11/03/2011

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	protection for 1 of 1 linen chutes. LSC 19.5.4.2 requires any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. This deficient practice affects any resident or staff near the linen chute in the event of an emergency. Findings include: Based on observation with Maintenance Technician # 1 on 10/03/11 at 2:20 p.m., a sprinkler pipe or a sprinkler head could not be seen in, or around, the linen chute. Based on an interview with Maintenance Technician # 1 at the time of observation, he could not confirm the linen chute was provided with sprinkler protection. 3.1-19(b)		areas of this facility.(3) Shambaugh and Sons have added this sprinkler head to the quarterly inspection test to verify operability. (4) The Plant Operations and Maintenance Supervisor will oversee that quarterly inspections are maintained on all sprinkler systems and that a report is given to the Quality Assessment & Assurance Committee to verify compliance.	

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K0074 SS=E	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on observation and interview, the facility failed to ensure window curtains in 12 of 12 resident rooms in Alpenrose and 4 of 4 common areas were flame retardant. This deficient practice could affect any number of residents. Findings include: Based on observations with Maintenance Technician # 1 on 10/03/11 from 12:02 p.m. to 12:40 p.m., window coverings were observed in the following locations: a) all twelve resident rooms in Alpenrose	K0074	**POC** (1) Swiss Village does have fire-rating certification for the curtains and drapes in the areas identified. Unfortunately the Plant Operations Supervisor who maintains the documentation was away from the facility on vacation during the LSC survey and even though the documentation was completed and in the designated book binder, Maintenance Technician # 1 was not able to find and produce the documentation for the surveyor. (2) The Plant Operations Supervisor reviewed the contents and location of documents with fire retardant rating information on draperies, carpet and furniture with Maintenance Technician # 1, Director of Healthcare Services, Director of Resident Services and Executive Director for all areas so	11/03/2011

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	b) Alpenrose Activity center c) Edelweiss administration corridor d) Edelweiss private dining room e) Edelweiss lounge Based on interview with Maintenance Technician # 1 at 12:02 p.m., tags on the window covering could not be found and there was no documentation regarding flame retardancy for these window coverings available for review. 3.1-19(b)		that in the future it can be found and produced during the survey. (3) The Plant Operations Director will produce a duplicate copy of the documentation and provide to the Director of Healthcare to allow for ready access to the required information. (4) The Director of Healthcare Services will report quarterly to the Quality Assessment & Assurance Committee verifying that the documentation is current and readily available.	
K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was	K0143	**POC** (1) The oxygen storage room has natural ventilation and a power ventilation system is ordered and will be installed by	11/15/2011

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	provided with continuous mechanical ventilation. This deficient practice could affect any resident near the oxygen transferring room. Findings include: Based on observation with Maintenance Technician # 1 on 10/03/11 at 1:35 p.m., the oxygen transferring room with at least five large stationary liquid oxygen cylinders was provided with only a fresh air vent. Maintenance Technician # 1 was not aware of this requirement for an oxygen transferring room. 3.1-19(b)		November 15, 2011. The later date is caused by delay in shipping. It will be installed as soon as it arrives. (2) This is the only oxygen storage room at this facility. (3) To verify that continuous mechanical ventilation is being provided in the oxygen storage area, a visual inspection will occur monthly and logged that it is functioning properly. (4) The Plant Operations and Maintenance Supervisor will report quarterly to the Quality Assessment & Assurance Committee the documented results of the monthly inspections.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 2 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be	K0144	**POC** (1) Documentation of the monthly load test for August and September of 2011 existed but were not made available during the survey (See Exhibits 6 & 7). Unfortunately the Plant Operations Supervisor who maintains the documentation was away from the facility on vacation during the LSC survey and even	11/03/2011

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	in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review of the generator logs titled "Test Log" for both the Admin. generator and the Edelweiss generator with Maintenance Technician # 1 on 10/03/11 at 11:23 a.m., a monthly load test was not documented for the months of August and September of 2011. Based on an interview with		though the documentation was completed the Maintenance Technician # 1 was not able to find and produce the documentation for the surveyor. (2) Documentation was available for the weekly and monthly generator tests for both generator units. (3) The Plant Operations Supervisor reviewed the contents and location of documents for the weekly and monthly generator tests with the Maintenance Technician # 1, Director of Healthcare Services, Director of Resident Services and Executive Director. (4) The Plant Operations Director will report quarterly to the Quality Assessment & Assurance Committee documentation verifying that the documentation for both the weekly and monthly tests of the generators is current and readily available.	

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	Maintenance Technician # 1 at the time of record review, no other documentation was available for review. 3.1-19(b)			